PA 13-208—sHB 6644
Public Health Committee
Finance, Revenue and Bonding Committee

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES

SUMMARY: This act makes numerous substantive and minor changes to Department of Public Health (DPH)-related statutes and programs. For example, the act requires licensed health care institutions to submit to DPH corrective action plans after the department finds the institution to be noncompliant with state laws or regulations.

The act limits required background checks for long-term care facility volunteers with direct patient access to only those volunteers reasonably expected to regularly perform duties substantially similar to those of employees with direct patient access. It eliminates the Connecticut Homeopathic Medical Examining Board, transferring responsibility for disciplining homeopathic physicians from the board to DPH.

The act makes changes affecting several health care professions and institutions, including master social workers, physician assistants, marital and family therapists, nuclear medicine technologists, optometrists, dental hygienists, certified water treatment plant professionals, hospice and nursing home facilities, residential care homes (RCHs), outpatient clinics, family day care homes, barber and hairdresser schools, and hospitals.

The act also makes changes affecting the Connecticut Tumor Registry, the Breast and Cervical Cancer Early Detection and Treatment Referral Program, the Biomedical Research Trust Fund, the Health Information Technology Exchange of Connecticut, permits for public water supply dam construction, disclosure of patient information by certain health care providers, statutory definitions related to addiction services, the registration of swine growers, the state's electronic prescription drug monitoring program, the Alzheimer's Disease and Dementia Task Force established by SA 13-11, and the PANDAS/PANS advisory council established by PA 13-187.

EFFECTIVE DATE: October 1, 2013, except that the provisions on the:

1. Connecticut Tumor Registry, Alzheimer's Disease and Dementia Task Force, PANDAS/PANS advisory council, coronary angioplasty hospital reports, registration of swine growers, and electronic prescription drug monitoring program take effect upon passage;
2. barber and hairdresser schools, nuclear medicine technologists, and the definition of RCHs take effect July 1, 2013;
3. Breast and Cervical Cancer Early Detection and Treatment Referral Program and outpatient clinics take effect January 1, 2014; and
4. optometrists' continuing education requirements apply to registration

periods on and after October 1, 2014.

§ 1 — BIOMEDICAL RESEARCH TRUST FUND

By law, DPH awards grants from the Biomedical Research Trust fund for biomedical research in heart disease, cancer, other tobacco-related diseases, Alzheimer's disease, and diabetes. DPH also uses a portion of the fund to cover the administrative cost of awarding the grants. The act codifies this practice by making up to 2% of the fund's total amount available to DPH for related administrative expenses.

Existing law limits the total amount of grants awarded during a fiscal year to 50% of the fund's total amount on the date the grants are approved. The act specifies that each fiscal year, the DPH commissioner must use all monies deposited in the fund to award the grants, provided the grants do not exceed this amount.

Existing law allows DPH to award the grants to (1) nonprofit, tax-exempt colleges or universities or (2) hospitals that conduct biomedical research. The act limits grant eligibility to such entities whose principal place of business is in Connecticut.

§ 2 — BREAST AND CERVICAL CANCER EARLY DETECTION AND TREATMENT REFERRAL PROGRAM

The act increases the income limit, from 200% to 250% of the federal poverty level, for DPH's Breast and Cervical Cancer Early Detection and Treatment Referral Program. It retains the existing requirements that participants also (1) be 21 to 64 years old and (2) lack health insurance coverage for breast cancer screening mammography or cervical cancer screening services.

The act removes a requirement that the program's contracted providers report to DPH the names of the insurer of each such woman being tested to facilitate recoupment of clinical service expenses to the department.

By law, the program provides, within existing appropriations, participants with (1) clinical breast exams, (2) screening mammograms and pap tests, and (3) a pap test every six months for women who have tested HIV positive.

§ 3 — BACKGROUND CHECKS FOR LONG-TERM CARE FACILITY VOLUNTEERS

Under prior law, a long-term care facility had to require any person offered a volunteer position involving direct patient access to submit to a background search, which included (1) state and national criminal history record checks, (2) a review of DPH's nurse's aide registry, and (3) a review of any other registry that DPH specifies.

The act conforms to federal law (P.L. 111-148, § 6201(a)(6)) by limiting the background search requirement to only those volunteers the facility reasonably expects to regularly perform duties substantially similar to those of an employee with direct patient access.

The law, unchanged by the act, does not require the background search if the person provides the facility evidence that a background search carried out within three years of applying for the volunteer position revealed no disqualifying offense.

§§ 4 & 5 — INPATIENT HOSPICE FACILITIES

The act adds to the statutory definition of health care "institution" a "short-term hospital special hospice" and "hospice inpatient facility." The terms are not defined in statute but appear in the department's hospice regulations (see BACKGROUND). Thus, the act extends to these entities statutory requirements for health care institutions regarding, among other things, workplace safety committees, access to patient records, disclosure of HIV-related information, and smoking prohibitions.

The act also establishes biennial licensing and inspection fees for these entities, as follows:

1. for short-term hospitals special hospice, $940 per site and $7.50 per bed (DPH currently charges these facilities the same renewal fees as hospitals, which equal these amounts) and
2. for hospice inpatient facilities, $440 per site and $5 per bed.

§ 6 — APPLICATION FEE FOR FAMILY DAY CARE HOME STAFF

The act makes a conforming change in the family day care home statutes, reducing the application fee, from $20 to $15, for assistant or substitute staff members. The law requires these individuals to apply for and obtain DPH approval before working in a family day care home.

§ 7 — CORRECTIVE ACTION PLANS FOR LICENSED HEALTH CARE INSTITUTIONS

The act removes the one-year time limit within which DPH-licensed health care institutions must comply with any regulations the department adopts. It retains the existing requirement that they comply within a reasonable time (the act does not define this term).

The act allows DPH to inspect a licensed health care institution to determine whether it is in compliance with state statutes and regulations (the law already allows this). The department must notify an institution in writing if it finds it to be noncompliant. Within 10 days after receiving the notice, the act requires the institution to submit to DPH a written corrective action plan that includes the:

1. corrective measures or systemic changes the institution intends to implement to prevent a recurrence of each identified non-compliance issue;
2. effective date of each corrective measure or systemic change;
3. institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

4. title of the institution's staff member responsible for ensuring its compliance with the plan.

Under the act, the corrective action plan is deemed the institution's representation of compliance with the statutes and regulations identified in the department's noncompliance notice. An institution failing to submit a corrective action plan that meets the above requirements may be subject to disciplinary action, such as license revocation or suspension, censure, letter of reprimand, or probation.

§ 8 — NURSING HOME IV THERAPY PROGRAMS

The act allows a licensed physician assistant employed or contracted by a nursing home that operates an IV (intravenous) therapy program to administer a peripherally-inserted central catheter (PICC) as part of the home's IV therapy program. The law already allows an IV therapy nurse to do this. A PICC is a tube that is inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip ends in a large vein in the chest near the heart to obtain intravenous access.

DPH must adopt regulations to implement this change.

§ 9 — HEALTH INFORMATION TECHNOLOGY EXCHANGE OF CONNECTICUT (HITE-CT)

The act requires the governor to select the chairperson of HITE-CT's 20-member board of directors, rather than having the DPH commissioner or her designee serve as the chair.

HITE-CT is a quasi-public agency designated as the state's lead agency for health information exchange. It is responsible for, among other things, (1) developing a statewide health information exchange to share electronic health information among health care facilities, health care professionals, public and private payors, and patients; (2) providing grants to advance health information technology and exchange in the state; and (3) implementing and periodically revising the state's health information technology plan.

§ 10 — MASTER SOCIAL WORK LICENSURE WITHOUT EXAMINATION

The act extends, from October 1, 2012 to October 1, 2015, the date by which the DPH commissioner may issue a master social work license without examination. To receive such a license, an applicant must satisfactorily demonstrate that on or before October 1, 2013, instead of October 1, 2010 as under prior law, he or she (1) held a master's degree from a social work program accredited by the Council on Social Work Education or (2) if educated outside of the United States or its territories, completed a program the council deemed equivalent.

PA 10-38 established, within available appropriations, a new DPH licensure program for master level social workers, which the department has not yet implemented.

§ 11 — ACTIVE DUTY PHYSICIAN ASSISTANTS

The act allows a physician assistant who is (1) licensed in another state and (2) an active member of the Connecticut Army or Air National Guard to provide patient services under the supervision, control, responsibility, and direction of a Connecticut-licensed physician while in the state.

§§ 12 & 13 — CONTINUING EDUCATION FOR OPTOMETRISTS

The act allows, rather than requires, DPH to adopt regulations regarding continuing education (CE) requirements for optometrists and establishes these requirements in statute. Prior law required DPH to adopt regulations requiring at least 20 hours of CE during each registration period (i.e., the 12-month period for which a license is renewed).

CE Requirements

Starting with registration periods on or after October 1, 2014, the act generally requires a licensee actively engaged in the practice of optometry to complete at least 20 hours of CE each registration period. It defines "actively engaged in the practice of optometry" as treating one or more patients during a registration period.

The act requires CE subject matter to reflect the licensee's professional needs in order to meet the public's health care needs. It must include at least six hours in (1) pathology, diabetes detection, or ocular treatment and (2) treatment related to the use of ocular agents-T (see BACKGROUND). It cannot include more than six hours in practice management.

Coursework must be provided through direct, live instruction physically attended by the licensee either (1) individually; (2) as part of a group of participants; or (3) through formal home study or a distance learning program, which the act limits to six hours.

Qualifying CE Activities

Under the act, qualifying CE activities include courses offered or approved by:

1. the Association of Regulatory Boards of Optometry's Council on Optometric Practitioner Education (COPE);
2. the American Optometric Association (AOA) or affiliated state or local optometry associations and societies;
3. a hospital or other health care institution;
4. an optometry school or college or other higher education institution accredited or recognized by COPE or AOA;
5. a state or local health department; or
6. a national, state, or local medical association.

License Renewal

The act requires that each licensee applying for renewal sign a statement

attesting that he or she completed the CE requirements on a form DPH prescribes.

Each licensee must get an attendance record or certificate of completion from the CE provider for all hours successfully completed. He or she must retain this documentation for at least three years following the date the CE was completed or the license was renewed (the act does not specify whether it is the sooner or later date). The licensee must submit the documentation to DPH within 45 days of the department's request.

A licensee failing to comply with these requirements may be subject to DPH disciplinary action, including license revocation or suspension, censure, letter of reprimand, probation, or a civil penalty.

CE Exemptions and Waivers

A licensee applying for his or her first renewal is exempt from the CE requirements. A licensee not actively engaged in the practice of optometry is also exempt, provided he or she submits a notarized exemption application before the end of the registration period on a form DPH prescribes. In this case, the licensee cannot resume practicing optometry until completing the CE requirements.

DPH may also grant a waiver from the requirements or an extension of time for a licensee who has a medical disability or illness. The licensee must apply for a waiver or time extension to DPH and submit (1) a licensed physician's certification of the disability or illness and (2) any documentation the department requires. The waiver or extension cannot exceed one registration period. DPH may grant additional waivers or extensions if the initial reason for the waiver or extension continues beyond the waiver or extension period and the licensee applies.

Licensure Reinstatement

A licensee who applies for licensure reinstatement after his or her license was voided must submit evidence that he or she completed 20 contact hours (the act does not define this term) of CE within one year immediately preceding the application. It applies to an optometrist whose license was voided for failing to pay the renewal fee and renew the license within 90 days after the renewal date.

§§ 14 & 15 — DENTAL HYGIENISTS CONTINUING EDUCATION AND LICENSE RENEWAL

The act removes the requirement that DPH adopt regulations on CE requirements for dental hygienists and instead establishes the requirements in statute.

CE Requirements

The act generally requires each licensee applying for renewal to complete at least 16 hours of CE within the preceding two years (the same requirement as under current DPH regulations). The CE subject matter must reflect the licensee's professional needs in order to meet the public's health care needs. CE activities must provide significant theoretical or practical content directly related to clinical

or scientific aspects of dental hygiene.

A licensee may substitute eight hours of volunteer dental practice at a public health facility for one hour of CE, up to a maximum of five hours in one two-year period. Up to four hours of CE may be earned through an online or distance learning program.

Qualifying CE Activities

Under the act, qualifying CE activities include courses, including those online, that are offered or approved by:

1. dental schools and other higher education institutions accredited or recognized by the Council on Dental Accreditation;
2. a regional accrediting organization;
3. the American Dental Association or an affiliated state, district, or local dental association or society;
4. the National Dental Association;
5. the American Dental Hygienists Association or an affiliated state, district, or local dental hygiene association or society;
6. the Academy of General Dentistry or the Academy of Dental Hygiene;
7. the American Red Cross or American Heart Association, when sponsoring programs in cardiopulmonary resuscitation or cardiac life support;
8. the Veterans Administration and Armed Forces, when conducting programs at U.S. government facilities;
9. a hospital or other health care institution;
10. agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation;
11. local, state, or national medical associations; or
12. a state or local health department.

Under the act, activities that do not qualify toward meeting CE requirements include (1) professional organizational business meetings; (2) speeches delivered at luncheons or banquets; and (3) reading books, articles, or professional journals.

License Renewal; CE Exemptions and Waivers

The act's CE documentation requirements, exemptions, and waivers for dental hygienists are the same as those for optometrists (see § 13 above).

Licensure Reinstatement

A licensee who applies for licensure reinstatement after his or her license was voided must submit evidence that he or she successfully completed: (1) for licenses voided for two years or less, 24 contact hours of CE within the two years immediately preceding the application or (2) for licenses voided for more than two years, the National Board of Dental Hygiene Examination or the Northeast Regional Board of Dental Examiners' Examination in Dental Hygiene during the year immediately preceding the application. It applies to a dental hygienist whose license was voided for failing to pay the renewal fee and renew the license within 90 days after the renewal date.

§§ 16–21 & 79 — HOMEOPATHIC PHYSICIANS

Connecticut Homeopathic Medical Examining Board

The act eliminates the five-member Connecticut Homeopathic Medical Examining Board, thus transferring responsibility for taking disciplinary action against homeopathic physicians from the board to DPH. It makes technical and conforming changes related to the board's elimination.

Under prior law, the board was responsible for (1) hearing and deciding matters concerning homeopathic physician licensure suspension or revocation, (2) adjudicating complaints against homeopathic physicians, and (3) imposing sanctions when appropriate.

Homeopathic Physician Licensure Requirements

By law, a homeopathic physician must be licensed as a physician and complete at least 120 hours of post-graduate medical training in homeopathy at an institution or under the direct supervision of a licensed homeopathic physician.

The act requires training completed at an institution to be approved only by the American Institute of Homeopathy (AIH), instead of by either AIH or the Connecticut Homeopathic Medical Examining Board. It requires training completed under a physician's supervision to be approved by DPH, instead of the board.

§ 17 — CERTIFIED WATER TREATMENT PLANT PROFESSIONALS

The act specifies that no regulatory board may exist for the following DPH-certified professionals, thus making DPH responsible for their regulation and discipline:

1. water treatment plant operators;
2. distribution and small water system operators;
3. backflow prevention device testers;
4. cross connection survey inspectors, including limited operators;
5. conditional operators; and
6. operators in training.

§ 22 — ADDICTION SERVICES STATUTORY DEFINITIONS

The act makes a technical change to the definitions of "alcohol-dependent person" and "drug-dependent person" in the Department of Mental Health and Addiction Services-related statutes to reflect updated terminology in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which took effect in May 2013.

§ 23 — CONNECTICUT TUMOR REGISTRY

The act requires that reports to the Connecticut Tumor Registry include, along with other information required by existing law, available follow-up information on (1) pathology reports and (2) operative reports and hematology, medical

oncology, and radiation therapy consults, or abstracts of these reports or consults.

By law, the Connecticut Tumor Registry includes reports of all tumors and conditions that are diagnosed or treated in the state for which DPH requires reports. Hospitals, various health care providers, and clinical laboratories must provide such reports to DPH for inclusion in the registry. The act requires the reports to be submitted to DPH within six months after the diagnosis or first treatment of a reportable tumor, instead of by each July 1 as under prior law.

§§ 24-60 — DEFINITION OF RESIDENTIAL CARE HOMES

The act removes RCHs from the statutory definition of "nursing home facility" and establishes a separate definition for these homes. The act redefines an RCH as an establishment that (1) furnishes, in single or multiple facilities, food and shelter to two or more people unrelated to the proprietor and (2) provides services that meet a need beyond the basic provisions of food, shelter, and laundry.

Prior law defined a "nursing home facility" as (1) any nursing home, RCH, or rest home with nursing supervision (RHNS) that, in addition to personal care required in a RCH, provides nursing supervision under a medical director 24 hours per day or (2) any chronic and convalescent nursing home (CCNH) that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, or injuries.

Although RCHs were included in this definition, they do not provide nursing care. In practice, DPH licenses nursing homes at two levels of care: CCNH, which provides skilled nursing care, and RHNS, which provides intermediate care.

The act applies statutory provisions to RCHs that currently apply to nursing home facilities, except for those provisions that appear to apply only to nursing homes. Table 1 lists the statutory provisions that reference the prior definition of nursing home facilities. Under the act these provisions no longer apply to RCHs because they reference the act's new definition of nursing home facility.

Table 1: Statutory Provisions That No Longer Apply To RCHs

Statute	*Description*
§ 12-170aa	Circuit breaker property tax exemption for the elderly and totally disabled; relates to the income of the applicant's spouse
§ 12-170d	Rental rebate program for the elderly and totally disabled; relates to the income of the applicant's spouse
§ 12-170v	Municipal option property tax exemption; relates to the income of the applicant's spouse
§ 17b-262	Authority for the Department of Social Services (DSS) commissioner to adopt Medicaid regulations, including those requiring DSS to monitor admissions and prohibit admission of people with a primary psychiatric diagnosis if such admission would jeopardize federal reimbursement

§ 17b-347	Termination of Medicaid provider agreements by nursing home facilities and the determination of these facilities' self-pay patient rates
§ 17b-372	Small house nursing home pilot program
§ 19a-522(a)	DPH regulations regarding the health, safety, and welfare of nursing home facility residents, including medical staff and personnel qualifications; nursing and dietary services; classification of violations; patients' immunizations; and general operational conditions
§ 19a-536	Requires nursing home administrators to allow patients and their relatives and legal representatives to access facility inspection reports
§ 19a-539	Disclosures of additional costs to patients and enforcement of surety contracts related to Medicaid long-term care applicants
§§ 19a-551 & 19a-552	Management of nursing home facility patient funds and associated penalties for non-compliance
§ 19a-553	Requires nursing home administrators to notify law enforcement of any crimes committed by patients and establishes penalties for failure to do so

The act applies to RCHs the following statutory provisions that currently apply only to nursing homes:

1. requiring nursing home licensees to immediately notify the DPH commissioner of any criminal convictions or disciplinary actions involving owners and specified employees (CGS § 19a-491b) and
2. excluding nursing homes from the definition of "plenary guardian" in the statutes regarding the appointment and authority of guardians for individuals with intellectual disabilities (CGS § 45a-669).

The act also adds to the nursing home patients' bill of rights, the right of each RCH resident to be transferred or discharged from the home in accordance with state law. The law already provides this right to nursing home and chronic disease hospital patients.

§ 61 — NURSING HOME FACILITY AND RCH CITATIONS

The act requires the DPH commissioner to issue a citation against any nursing home facility or RCH that violates the state's long-term care criminal history and patient abuse background search program. The law already requires the commissioner to do this for facilities and homes that violate a statute or regulation relating to their licensure, operation, and maintenance.

By law, there are two types of citations, which are based on the nature of the violation. Class A violations are those that present an immediate danger of death or serious harm to a nursing home facility or RCH resident, and carry a penalty of up to $5,000. Class B violations present a probability of death or serious harm to a

resident in the reasonably forseeable future, and carry a penalty of up to $3,000.

§ 62 — APPLICATIONS TO CONSTRUCT PUBLIC WATER SUPPLY DAMS

The act requires a person who applies to the Department of Energy and Environmental Protection commissioner for a permit to construct a dam for a public drinking water supply to notify the DPH commissioner of the application.

§ 63 — DISCLOSURE OF PATIENT INFORMATION BY PHYSICIANS AND SURGEONS

The act (1) adds a reference to DPH-licensed health care providers erroneously deleted in 1996 from the statute pertaining to the disclosure of patient information by DPH-licensed physicians and surgeons and (2) makes related technical changes.

By law, physicians and surgeons cannot disclose any patient information or communications without the consent of the patient or his or her authorized representative except:

1. according to statute, regulation, or court rule;
2. to a physician's or surgeon's attorney or liability insurer for use in the provider's defense of an actual or reasonably likely malpractice claim;
3. to DPH as part of an investigation or complaint, if the records are related; or
4. if the physician or surgeon knows, or has a good faith suspicion, that a child, senior, or person with a disability is being abused.

The act specifies that these disclosure requirements apply to all DPH-licensed health care providers except for psychologists, psychiatrists, professional counselors, social workers, marital and family therapists, DMHAS-contracted providers, and researchers, each of which has its own statutory disclosure requirements.

§ 64 — HAIRDRESSER AND BARBER SCHOOLS

The act requires any program, school, or entity (i.e., entity) that offers instruction in barbering or hairdressing for remuneration to obtain a certificate of authorization from the Office of Higher Education's (OHE) executive director.

Under the act, each entity approved on or before July 1, 2013 by the Connecticut Examining Board for Barbers, Hairdressers, and Cosmeticians that applies to OHE for initial authorization must pay a $500 application fee, which must be made payable to the General Fund's private occupational school student protection account.

OHE's executive director must develop a process for prioritizing the authorization of these entities. They must comply with the act's provisions by the earlier of (1) July 1, 2015 or (2) when required by the executive director's authorization process.

Presumably, these entities would be subject to OHE's existing initial and renewal fees for private occupational school authorization certificates ($2,000 for

initial application if not previously authorized by the board, $200 for a renewal, and $200 for each initial and renewal branch authorization). Authorizations are renewable annually for the first three years, after which they are renewable for up to five years (CGS §§ 10a-22b(c) and 10a-22d).

The act prohibits an individual or entity from establishing a new barber or hairdressing entity on or after July 1, 2013 without first obtaining a certificate of authorization from OHE's executive director.

Existing law requires an individual or business to apply to OHE for authorization to operate a private occupational school, revise its authorization, and establish branches. Private occupational schools are defined as those that provide instruction in trade, industrial, commercial, service, and other occupations. Although barber and hairdressing schools appear to fall within this statutory definition, in practice they are regulated by DPH, in consultation with the Connecticut Examining Board for Barbers, Hairdressers, and Cosmeticians.

§ 65 — TASK FORCE ON ALZHEIMER'S DISEASE AND DEMENTIA

The act increases, from 23 to 24, the membership of the Task Force on Alzheimer's Disease and Dementia established under SA 13-11 by adding the Department of Developmental Services commissioner or his designee.

Task force members include, among others, the commissioners of social services, public health, emergency services and public protection, aging, labor, and banking.

§§ 66-68 — NUCLEAR MEDICINE TECHNOLOGISTS

The act (1) establishes a statutory definition of "nuclear medicine technologist," (2) defines the practice of nuclear medicine technology, and (3) makes related technical changes. Under the act, as under existing law, DPH does not license or certify these health care professionals.

Definition of Nuclear Medicine Technologist

The act defines a "nuclear medicine technologist" as a person who holds and maintains current certification in good standing with the (1) Nuclear Medicine Technology Certification Board (NMTCB) or (2) American Registry of Radiologic Technologists (ARRT).

Scope of Practice

Under the act, the practice of nuclear medicine technology includes the use of sealed and unsealed radioactive materials, as well as pharmaceuticals, adjunctive medications, and imaging modalities with or without contrast as part of diagnostic evaluation and therapy. The technologist's responsibilities include patient care, quality control, diagnostic procedures and testing, administration of radiopharmaceutical and adjunctive medications, in vitro diagnostic testing, radionuclide therapy, and radiation therapy.

The act allows a nuclear medicine technologist to perform nuclear medicine

procedures under the supervision and direction of a DPH-licensed physician if (1) the physician is satisfied with the technologist's ability and competency; (2) such delegation is consistent with the patient's health and welfare and in keeping with sound medical practice; and (3) such procedures are performed under the physician's oversight, control, and direction.

The act's provisions do not apply to the activities and services of a person enrolled in a nuclear medicine technology educational program if the (1) program is acceptable to the NMTCB or ARRT and (2) activities or services are incidental to the student's course of study.

Prohibited Activities

The act prohibits a nuclear medicine technologist from (1) operating a stand-alone computed tomography imaging system (CT scan), except as provided below or (2) independently performing a nuclear cardiology stress test, except that the technologist can perform the imaging portion of the test and administer adjunct medications and radio pharmaceuticals.

Computed Tomography Imaging Systems

Prior law specified that a radiographer license was not required for a nuclear medicine technologist certified by the International Society for Clinical Densitometry or the ARRT if the technologist was operating a bone densitometry system under a licensed physician's supervision, control, and responsibility.

The act instead specifies that the radiographer licensure statutes do not prohibit a nuclear medicine technologist from fully operating a CT or magnetic resonance imaging (MRI) portion of a hybrid-fusion imaging system, including diagnostic imaging, in conjunction with a (1) positron emission tomography or (2) single-photon emission CT imaging system. The nuclear medicine technologist must (1) have successfully completed the individual certification exam for CT or MRI administered by the ARRT and (2) hold and maintain in good standing CT or MRI certification by the ARRT.

§ 69 — HOSPITAL CORONARY ANGIOPLASTY REPORTS

The act establishes a new reporting requirement for hospitals that obtained a certificate of need from DPH's Office of Health Care Access to provide emergency, but not elective, coronary angioplasty services. From October 1, 2013 to September 30, 2014, these hospitals must report monthly to DPH on the number of people who received an emergency coronary angioplasty and were then discharged to another hospital to receive (1) an elective coronary angioplasty or (2) open-heart surgery.

The DPH commissioner must report, by January 15, 2015 to the Public Health Committee on information received in the hospitals' monthly reports.

§ 70 — MARITAL AND FAMILY THERAPIST LICENSURE

By law, applicants for a marital and family therapist license must, among

other things, complete a graduate degree program and a supervised practicum or internship with an accredited (1) college or university or (2) post-graduate clinical training program. Previously, the post-graduate clinical training program had to be approved by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) and recognized by the U.S. Department of Education. This act instead requires that the training program be (1) accredited by COAMFTE and (2) offered by a regionally accredited institution of higher education.

§ 71 — PANDAS/PANS ADVISORY COUNCIL

The act makes a technical change to PA 13-187, which establishes a DPH advisory council on pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS) and pediatric acute neuropsychiatric syndrome (PANS). It substitutes the words "advisory council" for "task force" for consistency and accuracy.

§ 72 — ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

The act amends a provision in PA 13-172 which, among other things, expands the reporting requirements under the Department of Consumer Protection's electronic prescription drug monitoring program. The act exempts from the program's reporting requirements:

1. hospitals, when dispensing controlled substances to inpatients, and
2. institutional pharmacies or pharmacist's drug rooms operated by a DPH-licensed health care institution, when dispensing or administering opioid antagonists directly to a patient to treat a substance use disorder.

PA 13-172 already exempts physicians from having to report dispensing samples of controlled substances to patients.

§ 73 — REGISTRATION OF SWINE GROWERS

The act reenacts a section of law that was repealed in 2012 relating to the registration of swine growers with the Department of Agriculture (DoAg) and the control of swine diseases. It:

1. requires anyone growing swine in one location for use or disposal at a different location to register with the DoAg commissioner;
2. authorizes the commissioner to issue orders and regulations for protecting swine from contagious and infectious diseases;
3. requires the commissioner to immediately investigate swine diseases and issue instructions for quarantines and disinfection of diseased premises;
4. requires most imported swine to be disease-free, as certified by a health official and accompanied by a DoAg permit; and
5. requires swine brought into the state for immediate slaughter to be killed in an approved slaughterhouse under veterinarian inspection.

By law, the penalty for diseased animal violations is a class D misdemeanor, subject to a fine of up to $500, up to three months' imprisonment, or both (CGS §

22-321).

Importing and Testing Swine

Under the act, as under the repealed law, swine cannot be imported into Connecticut unless they come from a validated brucellosis-free and pseudorabies-negative herd. Imported swine must come with a permit from the DoAg commissioner and an official health certificate that certifies the swine are free of infectious or contagious disease. Swine that are imported for immediate slaughter on federally inspected premises do not need a health certificate, but the owner of the premises must report to the commissioner weekly the number of such swine imported.

Swine imported for other than immediate slaughter that are over three months old, other than a barrow (i.e., castrated swine), must pass a brucellosis and pseudorabies blood test within 30 days of being imported. The state veterinarian may waive the 30-day blood test for swine imports from (1) a state validated to be brucellosis- and stage V pseudorabies-free, if the swine spent at least 30 days there before importation, or (2) a herd he determines is pathogen free.

§§ 74-76 —TECHNICAL CORRECTIONS

The act makes technical corrections in the following public health-related statutes:

1. the rehabilitation services commissioner's authorization to aid in securing certain employment for capable blind or partially blind individuals (CGS § 10-297),
2. minimum temperature standards for residential and commercial buildings (CGS § 19-109), and
3. continuing medical education requirements for DPH-licensed physicians and surgeons (CGS § 20-10b).

§§ 77 & 78 — OUTPATIENT CLINICS

The act establishes a statutory definition for "outpatient clinics" (these clinics are defined in DPH regulations) and adds them to the statutory list of health care institutions. In doing so, it extends to these clinics statutory requirements for health care institutions regarding, among other things, workplace safety committees, access to patient records, disclosure of HIV-related information, and smoking prohibitions.

The act defines an "outpatient clinic" as an organization operated by a municipality or corporation, other than a hospital, that provides:

1. ambulatory medical care, including preventive and health promotion services;
2. dental care; or
3. mental health services in conjunction with medical or dental care for the purpose of diagnosing or treating a health condition that does not require the patient's overnight care.

The act requires DPH to license outpatient clinics (it already does this). The

commissioner may adopt related regulations and waive any provision of these regulations for outpatient clinics. The act allows the commissioner to implement policies and procedures while in the process of adopting them in regulation, provided she prints notice of intent to adopt the regulations in the *Connecticut Law Journal* within 20 days of implementation. The policies and procedures are valid until final regulations take effect.

BACKGROUND

DPH Hospice Regulations (§§ 4 & 5)

DPH regulates hospices that are considered free-standing or established as a distinct unit within a health care facility (e.g., inpatient hospice facilities). DPH regulations define "hospice" under the broader category of "short-term hospital special hospice." Inpatient hospice facilities must meet a variety of requirements concerning their physical plants, administration, staffing, records, and infection control.

In 2012, DPH amended its hospice regulations, creating a second licensure category called "inpatient hospice facilities." The regulations keep the existing "short-term hospital special hospice" licensure category so that facilities that want to continue to provide hospice services at a hospital level of care may do so. The new "hospice facility" licensure category allows entities to create new facilities under regulations based on Medicare's minimum regulatory requirements for inpatient hospital facilities (42 CFR § 418.110). These requirements are less stringent than DPH's short-term hospital special hospice regulations (Conn. Agencies Reg., §§ 19a-495-5a to 19a-495-6m).

Ocular Agents-T (§§ 12 & 13)

"Ocular agents-T" are (1) topically administered ophthalmic agents and orally administered antibiotics, antihistamines, and antiviral agents used for treating or alleviating the effects of eye disease or abnormal conditions of the eye or eyelid, excluding the lacrimal drainage system and glands (tears) and structures behind the iris, but including the treatment of iritis and (2) orally administered analgesic agents for alleviating pain caused by these diseases or conditions.

Related Acts

PA 13-18 allows DPH to award Biomedical Research Trust Fund grants for biomedical research related to strokes.

OLR Tracking: ND:JR:JKL:RO